RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR SERVICES FOR INDIVIDUALS & FAMILIES

Food Stamps

DHS FOOD STAMP APPLICATION INSTRUCTION SHEET

The DHS Food Stamp Application has two (2) color-coded Sections. The Green section (Core Application) asks for basic information **needed for all DHS Programs for Children and Families**. The other section need to be completed for Food Stamp benefits. We hope this sheet is helpful as you to fill out the Application form for services. (NOTE: DHS can help you if you need assistance reading or filling out this application due to a disability or other reason.)

How do I apply for benefits?

- ✓ Fill out the Green (CORE) section of the application packet as completely as you can.
- ✓ Check off the type of program benefits you are applying for: child care, health care, food stamps and/or cash assistance.
- ✓ Next fill out the color coded PROGRAM sections of the application for all benefits you need:

  Green with Yellow Section is for Food Stamps (Food Stamps requires interview; either in person or in some circumstances over phone. Call DHS OFFICE FOR APPOINTMENT)

IMPORTANT! Turn in the application to DHS today if possible, or mail it to the nearest DHS office. This is important because some of your benefits, such as food stamps, may begin based on the date DHS receives this application. Once we have the form we can begin the process of reviewing your information and determining if you are eligible to receive Food Stamps. Bring as much proof as possible to your interview. **BUT DO NOT DELAY MEETING WITH THE WORKER, EVEN IF YOU DO NOT HAVE ALL NECESSARY PROOF TOGETHER. DHS MAY BE ABLE TO HELP YOU GET SOME OF THE PROOF NEEDED.**

What if I need Food Stamp benefits immediately because of an emergency?

- ✓ **If you need immediate help with food**, go to the office closest to you and speak with a DHS worker. Tell the DHS worker that you would like assistance with **Expedited Service for Food Stamps**. The worker will determine if you qualify. **Expedited Service** means that you may receive your food stamps within seven days. You must meet all Food Stamp requirements, but you do not need to have all of your documentation/proofs ready at that first meeting, just an identification (like a photo ID). You can bring proof of other information at a later date.

What is the next step to completing my application?

- ✓ Gather the verification documents (proofs) that are needed. SEE THE LIST ON THE OPPOSITE SIDE OF THIS INSTRUCTION SHEET TO KNOW WHAT PROOFS ARE NEEDED. If DHS needs more documentation (proofs) you will get a letter or a phone call telling you what else is needed.
- ✓ **Read your Rights and Responsibilities and SIGN THE LAST PAGE OF THE FOOD STAMP APPLICATION FORM YOU FILL OUT.**
- ✓ **Mail or if you prefer, drop off the completed application AND the documents (proofs) to one of the DHS offices listed on the opposite page of this sheet.**

NOTE: A COPY OF YOUR RIGHTS AND RESPONSIBILITIES IS INCLUDED WITH THESE INSTRUCTIONS. YOU SHOULD KEEP THIS FOR YOUR RECORDS. THIS SAME FORM WILL BE SIGNED IN THE APPLICATION PACKET AND THAT WILL BE THE COPY WE FILE IN OUR DHS CASE RECORD.

List of Documentation / Proofs you may need

✓ Use this check off list to help you prepare for the interview with your worker. Be sure to bring as many of these with you to your appointment, or if you are using the mail, to include the proofs needed for Food Stamps.

_____ Identification ID (like your Driver's License)

_____ Proof of where you live

_____ Proof of pregnancy

_____ Proof of Income (4 most recent pay stubs)

_____ Copy of Appointment Letter (if you have made your appointment)

_____ Social Security Numbers for everyone in your household who needs benefits

_____ Proof of expenses (like rent, utility bills, taxes, child care expenses, child support paid out)

_____ Birth certificates (all members of household applying for benefits)

_____ Citizenship verification (or proof that you have applied for this)

_____ Proof of the value of your assets (like cars, bank accounts and insurance)

_____ Proof of temporary illness or disability (physician's letter)

_____ Note from anyone in your household who purchases and prepares their food separately from yours

Listed below are the addresses and telephone numbers of the offices of the Department of Human Services in Rhode Island which administer programs for Individuals & Families:

You may also be eligible to receive childcare, health care, and/or cash assistance. Ask your DHS worker for more information about these programs. **All programs are not available at every office. (Child Care serves working parents throughout the state through Providence and Pawtucket offices only)**

DHS AREA OFFICES	ADDRESS	TELEPHONE
Cranston Office	600 New London Avenue Forand Building, 1st Floor Cranston, RI 02920	462-6500
Johnston Office	1514 Atwood Avenue Johnston, RI 02919	222-5666
Newport Family Center	Newport Family Center 110 Enterprise Center Middletown, RI 02842	849-6000 1-800-675-9397 Toll Free
North Kingstown Office	7734 Post Road North Kingstown, RI 02852	267-1030 1-800-862-0222 Toll Free
Pawtucket Family Center Pawtucket Food Stamps Office Child Care Assistance Unit (CCAU)	24 Commerce Street Pawtucket, RI 02860	729-5400 1-800-984-8989 Toll Free
Providence Regional Family Center Providence Food Stamps Office Child Care Assistance Unit (CCAU)	Providence Family Regional Center 206 Elmwood Avenue Providence, RI 02907	222-7000 222-7276 (FS) (TTY) 222-7032
Warwick Family Center Warwick Food Stamps Office	195 Buttonwoods Avenue Warwick, RI 02886	736-6511 1-800-282-7021 Toll Free
Woonsocket Family Center Woonsocket Food Stamp Office	450 Clinton Street Woonsocket, RI 02895	235-6300 (TTY) 235-6490 1-800-510-6988 Toll Free
Rite Care/Rite Share	Information Line	462-1300 (TTY) 222-2506 (Spanish Line) 462-1500
DHS HELPLINE	Information Line	462-5300

YOUR COPY

RIGHTS AND RESPONSIBILITIES

You have a RIGHT:

- To ask for help to complete your application or any other DHS form.
- To ask for forms and notices to be translated if you don't read English and to be provided with information in a format you can understand.
- To be treated with courtesy, consideration and respect.
- To be interviewed promptly when you apply and to have your eligibility determined within 30 days.
- To discuss your case with your DHS worker and to review your case when you request to do so.
- To receive Food Stamps within seven (7) days if you are eligible for expedited Food Stamps.
- To have a written notice mailed to you when your application is approved, denied, or when your benefits decrease or stop.
- To have your records kept confidential by DHS, unless otherwise provided for by law and to receive a hard copy of the DHS notice of privacy practices outlining your individual privacy rights and protections.
- To file a complaint or appeal and to ask for a hearing within 90 days for Food Stamps, of any action on your benefits that you think was wrong.
- To be represented at a hearing by yourself or a household member, friend, attorney, or other person of your choice. (You may get free legal help at your local RI Legal Services office – 274-2652).
- To refuse to provide information on your racial/ethnic heritage.
- To not be discriminated against, according to applicable Federal and State laws, on the basis of race, color, national origin, disability, sex, political beliefs, age, religion or sexual orientation.

You have a RESPONSIBILITY:

- To give the Department accurate information about your household's income, resources and living arrangements. (Making false statements or failing to report all the facts or situations that affect eligibility for benefits may result in stopping your household's benefits, repayment of benefits received incorrectly, and/or criminal or civil action.)
- For Food Stamps: to tell us immediately (within 10 days) of any changes in your household's income, resources, members, employment status, or other information you supplied on your application. This will allow DHS to be sure your household is receiving the correct type and amount of benefits.
- To tell us about and provide proof of shelter, medical and dependent care costs. If you do not report or provide proof of these costs, they will not be used to help figure your benefits.
- To cooperate fully with State and Federal personnel conducting Quality Control reviews. This is a random selection of cases to be reviewed.
- To supply Social Security numbers for all members of your household who are required to have one, or to apply for them as a condition of eligibility. These Social Security numbers will be used in a computer match with other government agencies, and will be verified electronically where possible. Income and eligibility information obtained will be used to make sure your household or the person who has applied for benefits are eligible for and receiving the correct amount of benefits.

I UNDERSTAND that by signing this application:

- DHS can pursue any payments that may be due from a third party as a result of an accident, injury, or illness, including any claims for Workers' Compensation.
- DHS can obtain from medial providers, information that is pertinent to me or any person included in this application for as long as my case remains open.
- DHS can contact other persons or organizations to get proof of my eligibility and level of benefits.
- DHS has my consent to use or disclose protected health information for the purposes of treatment, payment and health care operations in accordance with DHS notice of privacy practices.
- DHS can use or share information on this application for the administration of DHS programs, as well as the administration of other federally funded assistance programs in accordance with state and federal law.
- DHS can release non-identifying information for research purposes. Any release of identifying information shall be done in accordance with state and federal law.

I understand my rights and responsibilities. I agree to comply with my responsibilities. I also understand that penalties for giving wrong or incomplete facts and failing to report facts or situations which may affect my eligibility or benefit level may result in fines or imprisonment. I certify under penalty of perjury that all of the information contained in this application is true.

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
APPLICATION FOR FOOD STAMP SERVICES
FOR
INDIVIDUALS & FAMILIES

Your Last Name:_____ Your Date of Birth: ____/____/____
MM DD YY

Your First Name:_____ Your Social Security Number:____/____/____

Your Middle Initial:_____ Maiden/Other Names:_____

Your Address (where you live):_____Apartment/Floor:_____

City:_____ State:_____ Zip:_____

Your Mailing Address (if different):_____ Apartment/Floor:_____

City:_____ State:_____ Zip:_____

Your Telephone Number (home):_____ Other:_____

Do you need help filling out this application? ☐ Yes ☐ No

If you have a disability or condition that makes it hard for you to understand or answer questions on this application, we can help. For example, we can read the form with you and write your answers for you. We can make other accommodations, depending on what assistance you need. Please let us know.

What language do you prefer to use?_____
**(RI DHS will provide an interpreter at no cost to you.)
Would you like to speak with a social worker about your living situation? ☐ Yes ☐ No

⟹ ⟹ **EXPEDITED FOOD STAMPS**

THIS SECTION WILL HELP US KNOW IF YOU CAN GET FOOD STAMPS FASTER UNDER SPECIAL FOOD STAMP RULES.

1. Will your household's income before taxes for the month be less than $150.00? ☐ Yes ☐ No
2. Does your household have less than $100 in cash, checking and savings? ☐ Yes ☐ No
3. Is anyone in your household a migrant or seasonal farm worker? ☐ Yes ☐ No

4. Shelter Expenses: Amount of current rent/mortgage $_____

Current monthly utility expenses $_____

Total $_____

5. Income & Resources: Income before taxes expected this month $_____

Money in cash, checking & savings $_____

Total $_____

I CERTIFY THAT THE INFORMATION CONTAINED ON THIS PAGE IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND THAT THERE ARE PENALTIES FOR NOT TELLING THE TRUTH ABOUT MYSELF AND MY FAMILY.

_____ _____
Signature of Applicant Date

1. List everyone living in your home on THIS SIDE of the line.
*If the person is asking for assistance, fill out the information on the other side of this line.

List the information on THIS SIDE of the line ONLY IF THE PERSON IS REQUESTING BENEFITS.
The information you give us about Race and Ethnicity will help us to know if we are following the Civil Rights laws. You are not required to give us this information. You may check off more than one box for each person's Race.

PREG

Last, First Middle	Date of Birth (MM/DD/YY)	Sex	Applying for Food Stamps	Social Security Number(s)	U.S. Citizen	Hispanic Or Latino	Race	Pregnant	Marital Status	Last School Grade Completed
1.a. Relationship to you:		☐F ☐M	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No	☐White ☐Asian ☐Black or African-American ☐Native Hawaii or Other Pacific Islander ☐American Indian or Alaskan Native	☐Yes Due Date: ☐No	☐Married ☐Never Married ☐Separated ☐Divorced ☐Widowed	
1.b. Relationship to you:		☐F ☐M	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No	☐White ☐Asian ☐Black or African-American ☐Native Hawaii or Other Pacific Islander ☐American Indian or Alaskan Native	☐Yes Due Date: ☐No	☐Married ☐Never Married ☐Separated ☐Divorced ☐Widowed	
1.c. Relationship to you:		☐F ☐M	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No	☐White ☐Asian ☐Black or African-American ☐Native Hawaii or Other Pacific Islander ☐American Indian or Alaskan Native	☐Yes Due Date: ☐No	☐Married ☐Never Married ☐Separated ☐Divorced ☐Widowed	
1.d. Relationship to you:		☐F ☐M	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No	☐White ☐Asian ☐Black or African-American ☐Native Hawaii or Other Pacific Islander ☐American Indian or Alaskan Native	☐Yes Due Date: ☐No	☐Married ☐Never Married ☐Separated ☐Divorced ☐Widowed	
1.e. Relationship to you:		☐F ☐M	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No	☐White ☐Asian ☐Black or African-American ☐Native Hawaii or Other Pacific Islander ☐American Indian or Alaskan Native	☐Yes Due Date: ☐No	☐Married ☐Never Married ☐Separated ☐Divorced ☐Widowed	
1.f. Relationship to you:		☐F ☐M	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No	☐White ☐Asian ☐Black or African-American ☐Native Hawaii or Other Pacific Islander ☐American Indian or Alaskan Native	☐Yes Due Date: ☐No	☐Married ☐Never Married ☐Separated ☐Divorced ☐Widowed	
1.g. Relationship to you:		☐F ☐M	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No	☐White ☐Asian ☐Black or African-American ☐Native Hawaii or Other Pacific Islander ☐American Indian or Alaskan Native	☐Yes Due Date: ☐No	☐Married ☐Never Married ☐Separated ☐Divorced ☐Widowed	

2. Did you move to Rhode Island from another state or country in the last three (3) months?
☐ **Yes** ☐ **No** If "NO", go to QUESTION 3. If "YES", please fill in the information below.

Date of Move: _____ What State or Country did you move from? _____

What was your reason for moving to Rhode Island?
☐ Relatives ☐ Looking for Work ☐ Domestic Violence ☐ Welfare Reform ☐ Other Reason

DISA

3. Are you or is anyone in your household unable to work or care for a child because of a disability?
☐ **Yes** ☐ **No** If "NO", go to QUESTION 4. If "YES", please fill in the information below.

Name of person with disability: _____

(You must give us proof of the illness or disability. We will give you a form to take to your doctor. A letter from Social Security for SSI or RSDI based on disability is also proof.)

SCHL

4. Are you or is anyone in your household age 16 or older and in school or training program?
☐ **Yes** ☐ **No** If "NO", go to QUESTION 5. If "YES", please fill in the information below.

Name of Student: _____ Name of School or Training Program: _____

Graduation or Finish Date: _____ Is this person an ☐ **adult or** ☐ **child?**

Name of Student: _____ Name of School or Training Program: _____

Graduation or Finish Date: _____ Is this person an ☐ **adult or** ☐ **child?**

5. Are you or is anyone in your household a veteran, spouse of a veteran, or child of a veteran?
☐ **Yes** ☐ **No** If "NO", go to QUESTION 6. If "YES", please fill in the information below.

Name of Veteran: _____

Name of Spouse: _____

Name of Child: _____

GROP

6. Are you, your spouse, or anyone in your household living in any of the places listed below?
☐ **Yes** ☐ **No** If "NO", go to QUESTION 7. If "YES", please fill in the information below.

☐ Own or rent apartment or home
☐ Living in another person's apartment or home
☐ Battered Women's shelter
☐ Homeless (car, street, other)

☐ Group living facility:
- ○ Homeless Shelter
- ○ Transitional Housing
- ○ Residential Care / Assisted Living Facility
- ○ Drug / Alcohol Treatment Center
- ○ Halfway House
- ○ Group Home
- ○ Hospital

Name of Person in group living facility: _____

Name of Facility: _____

ALIE

7. Is there anyone in your household applying for assistance who is not a United States citizen?
☐ Yes ☐ No

If "NO", go to QUESTION 8. If "YES", please fill in the information below.
Each DHS assistance program has rules about citizenship. The person's immigration status, how long the person has been in the United States, and how long the person has lived in Rhode Island all must be looked at so that a decision can be made about who is eligible for each program. Please read the "Immigration Status Information Sheet" that came with this application.
We will not share this information with anyone else including Immigration and Naturalization Services (INS).

7.a Name of non-citizen:_____
Alien Registration Number:_____
Lived in the United States before 8/22/96? ☐ Yes ☐ No
Lived in Rhode Island before 7/01/97? ☐ Yes ☐ No
Date entered the United States: _____
Immigration Status Number:_____ ⇨ ⇨ ⇨
Name of Sponsor:_____

7.b Name of non-citizen:_____
Alien Registration Number:_____
Lived in the United States before 8/22/96? ☐ Yes ☐ No
Lived in Rhode Island before 7/01/97? ☐ Yes ☐ No
Date entered the United States:_____
Immigration Status Number:_____ ⇨ ⇨ ⇨
Name of Sponsor:_____

7.c Name of non-citizen:_____
Alien Registration Number:_____
Lived in the United States before 8/22/96? ☐ Yes ☐ No
Lived in Rhode Island before 7/01/97? ☐ Yes ☐ No
Date entered the United States:_____
Immigration Status Number:_____ ⇨ ⇨ ⇨
Name of Sponsor:_____

7.d Name of non-citizen:_____
Alien Registration Number:_____
Lived in the United States before 8/22/96? ☐ Yes ☐ No
Lived in Rhode Island before 7/01/97? ☐ Yes ☐ No
Date entered the United States:_____
Immigration Status Number:_____ ⇨ ⇨ ⇨
Name of Sponsor:_____

Use the numbers below to tell us the person's Immigration Status:

1. Legal Permanent Resident
2. Admitted as a Refugee
3. Granted Asylum
4. Granted Withholding of Deportation
5. Granted Conditional Entry
6. Paroled into U.S. for at Least one year
7. Cuban / Haitian
8. Temporary Visitors Visa
9. Other (includes all other documented and undocumented statuses)

Note: You must give us proof of immigration status from INS.

JINC

8. Do you or does anyone in your household have income from working? ☐ Yes ☐ No
If "NO", go to QUESTION 9. If "YES", please fill in the information below for each person who is working.

You must give us proof of income: Include pay stubs for the last 4 weeks (or one month's worth of income) or a letter from your employer that shows the company name, the number of hours you work, the amount of your pay before taxes, and how often you are paid. If you just started working, a letter from your employer that tells us how many hours a week you will be working and how much you will be making is good proof. If you just left a job, a letter from your employer telling us the last day you worked, how much you made during the month, and if you have any more pay coming is good proof.

8.a Name of person who is working:_____ Job Title:_____
Employer's Name:_____ Hours Worked Each Week:_____
Employer's Address:_____ Pay Before Taxes:_____
_____ Amount of Tips:_____
Employer's Phone Number:_____ Is Earned Income Tax Credit added in?
Date employment began:_____ ☐ Yes ☐ No
Is this a college work study program? ☐ Yes ☐ No How often paid? ☐ Weekly
Will employment continue? ☐ Yes ☐ No ☐ Every Two Weeks
Does Employer offer health insurance: ☐ Yes ☐ No ☐ Twice a Month
☐ Once a Month
☐ Other

8.b Name of person who is working:_____ Job Title:_____
Employer's Name:_____ Hours Worked Each Week:_____
Employer's Address:_____ Pay Before Taxes:_____
_____ Amount of Tips:_____
Employer's Phone Number:_____ Is Earned Income Tax Credit added in?
Date employment began:_____ ☐ Yes ☐ No
Is this a college workstudy program? ☐ Yes ☐ No How often paid: ☐ Weekly
Will employment continue? ☐ Yes ☐ No ☐ Every Two Weeks
Does Employer offer health insurance? ☐ Yes ☐ No ☐ Twice a Month
☐ Once a Month
☐ Other

8.c Name of person who is working:_____ Job Title:_____
Employer's Name:_____ Hours Worked Each Week:_____
Employer's Address:_____ Pay Before Taxes:_____
_____ Amount of Tips:_____
Employer's Phone Number:_____ Is Earned Income Tax Credit added in?
Date employment began:_____ ☐ Yes ☐ No
Is this a college work study program? ☐ Yes ☐ No How often paid: ☐ Weekly
Will employment continue? ☐ Yes ☐ No ☐ Every Two Weeks
Does Employer offer health insurance? ☐ Yes ☐ No ☐ Twice a Month
☐ Once a Month
☐ Other

RINC

9. Do you or does anyone in your household have income from rent? ☐ Yes ☐ No
If "NO", go to QUESTION 10. If "YES", please fill in the information below for the person who receives the rent.

Name of person with rental income:_____ Amount of rent received:_____

Does the person above live here? ☐ Yes ☐ No How often received:_____

Number of hours worked each week maintaining property:____ Total number of units in building:_____

Will this income continue? ☐ Yes ☐ No

(You must give us proof of the income, and also the mortgage principal and interest; property taxes; house insurance; any utilities provided; and repair expenses so we can know how much rental income to count.)

DCIN

10. Do you or does anyone in your household have income from taking care of children in your home? ☐ Yes ☐ No
If "NO", go to QUESTION 11. If "YES", please fill in the information below for the person who receives the income.

Name of person with child care income:_____ Amount received:_____

Number of hours worked each week:_____ How often received:_____

Number of children cared for:_____ Will this income continue: ☐ Yes ☐ No

(You must give us proof of your actual income and expenses if you want us to use them so we can know how much child care income to count.)

BUSI

11. Do you or does anyone in your household have income from self-employment (such as a home-based business, home sales, shellfishing)? ☐ Yes ☐ No
If "NO", go to QUESTION 12. If "YES", please fill in the information below for the person who receives the income.

Name of person with child care income:_____ Amount received:_____

Number of hours worked each week:_____ How often received:_____

Number of children cared for:_____ Will this income continue: ☐ Yes ☐ No

(You must give us proof of your actual income and expenses if you want us to use them so we can know how much child care income to count.)

RBIN

12. Do you or does anyone in your household have income from roomers or boarders? ☐ Yes ☐ No
If "NO", go to QUESTION 13. If "YES", please fill in the information below for the person who receives the income.

Name of person with child care income:_____ Amount received:_____

Number of hours worked each week:_____ How often received:_____

Number of children cared for:_____ Will this income continue: ☐ Yes ☐ No

This income includes:
☐ Room only
☐ Board (1 – 2 meals / day)
☐ Board (3 meals / day)

(You must give us proof of your actual income and expenses if you want us to use them so we can know how much income to count.)

UNEA, STIN

13. **Do you or does anyone in your household have any of the following income?** ☐ **Yes** ☐ **No**
If "NO", go to QUESTION 14. If "YES", please fill in the information below for the person who receives the income.

This question includes benefits and checks such as these:

- Unemployment Benefits
- Social Security (RSDI or SSDI)
- Child Support
- Payment from Lawsuit
- Workers Compensation
- Temporary Disability (TDI)
- School Financial Aid
- Alimony
- Veterans Benefits
- Money from family or friends to help with bills
- Social Security (SSI)
- Adoption or Foster Subsidy
- Payment from Insurance Claim
- Any other type of pensions or benefits

(You must give us proof of the type of benefit you receive with the amount and date on it.)

13.a Name of person with income:_____ Amount received:_____
Type of Income:_____ How often received:_____
Date this income was last received:_____ Will this income continue: ☐ Yes ☐ No

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13.b Name of person with income:_____ Amount received:_____
Type of Income:_____ How often received:_____
Date this income was last received:_____ Will this income continue: ☐ Yes ☐ No

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13.c Name of person with income:_____ Amount received:_____
Type of Income:_____ How often received:_____
Date this income was last received:_____ Will this income continue: ☐ Yes ☐ No

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13.d Name of person with income:_____ Amount received:_____
Type of Income:_____ How often received:_____
Date this income was last received:_____ Will this income continue: ☐ Yes ☐ No

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14. **Has anyone in your household applied for any benefits listed in question 13 and is waiting for a decision about being able to collect?** ☐ **Yes** ☐ **No**
If "NO", go to QUESTION 15. If "YES", please fill in the information below for the person who is waiting for an answer.

Name of person who has applied for benefits:_____ Date filed for benefit:_____

Type of benefit:_____

DCEX

15. **Do you or does anyone in your household pay someone to care for a child or a disabled adult?**
☐ **Yes** ☐ **No**
If "NO", go to QUESTION 16. If "YES", please fill in the information below for the person who pays this expense.

Name of person
who pays for this care:_____

Amount paid to this person:_____
How often paid:_____

Full name of person
who receives this care payment:_____

PARE

16. **Other than you and your spouse, are there any other parents with children under age 22 living with you?** ☐ **Yes** ☐ **No**
If "NO", go to QUESTION 17. If "YES", please fill in the information below with the name of the parent and his/her children.

Name of Parent(s)_____

Name of child:_____

Name of child:_____

Name of child:_____

17. **Have you or has anyone in your household been found guilty of receiving Cash Assistance, Medical Assistance, or Food Stamps in more than one state at the same time? This includes court or an administrative hearing.** ☐ **Yes** ☐ **No**
If "NO", read the section below for what you should do next. If "YES", please fill in the information below with the name of the person who was convicted. Then read the section below for what you should do next.

Name of person found guilty:_____ What state:_____ What date:_____

* IMPORTANT *

- **Remember to SIGN the last page of your Food Stamp application form.**
- **Please be sure to include the documents (proofs) required:**
- **Follow the instructions on the APPLICATION INSTRUCTION SHEET for what to do when you have finished.**

CASH, CARS, PROP, BANK, RESO

FS 1. Do you or does anyone in your household have any of the resources listed below?

☐ **Yes** ☐ **No**

If "NO", go to QUESTION FS 1.b. If "YES", please fill in the information below for each person who has a resource. Be sure to list anything of value on which a household member's name appears.

This question includes resources such as these. If the type of resource owned by a household member is not listed here, write it in "Other Resources."

Cash	Cars	Land	Stocks
Checking Account	Trucks	Home	Bonds
Savings Account	Motorcycles	Buildings	Life Insurance
Credit Union Account	Camper	Condominium	Burial Contract
Certificate of Deposit (CD)	Mobile Home	Time Share	
Money Market Account	Boat	Life Estate	

First Name of Person Who Owns Resource	Type of Resource	Value of Resource	Information About Resource
	Cash	**$**	
	Bank Account **Type:** _____	**$**	**Account #:** _____ **Name of Bank:** _____ **Co-Owner:** _____
	Bank Account **Type:** _____	**$**	**Account #:** _____ **Name of Bank:** _____ **Co-Owner:** _____
	Cars, Trucks, Motor Vehicles	**$**	**Account Owed:** _____ **VIN #** _____ **Any special equipment:** _____ **Vehicle is used for:** _____
	Cars, Trucks, Motor Vehicles	**$**	**Account Owed:** _____ **VIN #** _____ **Any special equipment:** _____ **Vehicle is used for:** _____
	Property	**$**	**Type of Property:** _____ **Is this property the home of you, your spouse or dependents?** ☐ **Yes** ☐ **No** **Address, if not your home:** _____
	Stocks, Bonds, Life Insurance, Burial Contract	**$**	**Type:** _____ **Policy Number:** _____
	Other	**$**	**Type:** _____

TRAN

FS 1.b. Did you or did anyone in your household sell, give away, or transfer any resources in the past 3 months? ☐ **Yes** ☐ **No**

If "NO", go to question FS 2. If "YES", please fill in the information below for each person who had the resource.

First name of person who owned the resource: _____ **Type of Resource:** _____

Value of Resource: _____ **Amount Received:** _____ **Date:** _____

QUIT, STRK

FS 2. Did you or did anyone in your household leave a job in the last 60 days?

☐ **Yes** ☐ **No**

If "NO", go to QUESTION FS 3. If "YES", please fill in the information below for each person who left a job.

First name of person who left a job: _____

Reason for leaving job: ☐ Quit ☐ Fired ☐ Laid Off ☐ On Strike

Date left job: _____
Date fired: _____
Date laid off: _____
Date strike began: _____

Employer's Name: _____

Employer's Address: _____

(City) (State) (Zip)

SUPP

FS 3. Do you or does anyone in your household pay child support or alimony?

☐ **Yes** ☐ **No**

If "NO", go to QUESTION FS 4. If "YES", please fill in the information below for each person who has this expense. We will need to see a court order for proof of this expense.

First name of person with child support order: _____ Amount paid: _____
Who is the child support for: _____ How often paid: _____
First name of person with alimony order: _____ Amount paid: _____
Who is the alimony for: _____ How often paid: _____

FMED

FS 4. Is there anyone in your household over age 60 or disabled who has medical expenses not covered by health insurance? ☐ **Yes** ☐ **No**

If "NO", go to QUESTION FS 5. If "YES", please fill in the information below for each person who has these expenses. We will need to see proof of these expenses in order to give you credit for them when we figure out your food stamp amount.

This question includes medical expenses such as these:

Health insurance premiums	Eyeglasses	Medicare premiums
Prescriptions	Hearing aids	Dental care

First name of person with medical expense: _____ Amount of Expense: _____

Type of expense: _____ How often: _____

EATS

FS 5. Does anyone in your household purchase and prepare their food separately?

☐ **Yes** ☐ **No**

If "NO", go to question FS 6. If "YES", please fill in the information below for each person who shops and cooks separately from you.

First Name: _____ First Name: _____ First Name: _____

First Name: _____ First Name: _____ First Name: _____

FS 6. Do you or does anyone in your household have any expenses for the place in which you are living? ☐ **Yes** ☐ **No**

If "NO", go to question FS 7. If "YES", please fill in the information below. We will need to see your most recent bills for these expenses in order to give you credit for them when we figure out your Food Stamp amount.

Type of Expense	Total Amount of this expense	Amount of expense you are responsible to pay	How often are you billed for this expense?
☐ Rent ☐ Mortgage ☐ Lot Rental ☐ Condominium Fees		$ Is this subsidized? ☐ Yes ☐ No (i.e., Section 8, Public Housing)	☐ Monthly _____ ☐ Weekly _____ ☐ Other _____
Property Taxes not included in mortgage:			☐ Monthly _____ ☐ Weekly _____ ☐ Other _____
Homeowner's Insurance not included in mortgage:			☐ Monthly _____ ☐ Weekly _____ ☐ Other _____
Electricity - Do you heat or cool with this? ☐ Yes ☐ No			☐ Monthly _____ ☐ Weekly _____ ☐ Other _____
Gas - Do you heat or cool with this? ☐ Yes ☐ No			☐ Monthly _____ ☐ Weekly _____ ☐ Other _____
Oil - Do you heat or cool with this? ☐ Yes ☐ No			☐ Monthly _____ ☐ Weekly _____ ☐ Other _____
Other type of heating or cooling:			☐ Monthly _____ ☐ Weekly _____ ☐ Other _____
Water/Sewer charges:			☐ Monthly _____ ☐ Weekly _____ ☐ Other _____
Telephone:			☐ Monthly _____ ☐ Weekly _____ ☐ Other _____
Roomer/Boarder: ☐ Includes room only ☐ Includes 1-2 meals/day ☐ Includes 3 meals/day			☐ Monthly _____ ☐ Weekly _____ ☐ Other _____

FS 7. Did you receive a Low Income Energy Assistance Program grant (LIHEAP) at your current address within the last 12 months?
☐ **Yes** ☐ **No**

FS 8. Choosing the "Head of Household" for Food Stamp Benefits.

If your household includes adult parents with children, or adults with parental control of children, you may choose a head of household for food stamp benefits. This person will get all notices, forms and benefits due to the household. All members must agree to this choice. You may change the head of household when your case is reviewed or when there is a change in the people who live in your household.

Name of "Head of Household": _____

FS 9. Choosing an "Authorized Representative" for Food Stamp Benefits.

An "Authorized Representative" is a person named by you to act on behalf of your household in applying for your Food Stamp benefits, or using your Food Stamp benefits. You can name someone if you want to. It is not required that you do so.

Name of "Authorized Representative": _____

Address: _____
(City) (State) (Zip)

FS 10. Choosing the "Alternate Payee".

You can name someone to be an "Alternate Payee" for your household, if you choose to. This person will have full access to your FIP cash and Food Stamps benefits. Any misspent by the Alternate Payee will not be replaced. **If** you wish to have an Alternate Payee, fill out the information below. Check off which benefits you want to be available to the Alternate Payee. It is not required that you have an "Alternate Payee".

☐ **FIP CASH** ☐ **FOOD STAMPS**

Name of Alternate Payee: _____

Address: _____
(City) (State) (Zip)

Relationship to you: _____

FS 11. Are you or is anyone in your household fleeing from the law enforcement agency on felony charges, or in violation of probation or parole according to a court?

☐ **Yes** ☐ **No**

If "NO", go to QUESTION FS 12. If "YES", please fill in the information below for each person.

Name of person: _____

FS 12. Have you or has anyone in your household ever been convicted after August 22, 1996 of a felony for the sale or distribution of drugs? ☐ **Yes** ☐ **No**

If "NO", you are finished with the Food Stamp section. If "YES", please fill in the information below for each person. Read the section below.

Name of person: _____ Date: _____ State: _____

- **Remember to sign the last page of this section. Then follow the directions on the Application Instruction Sheet for what to do next.**

RIGHTS AND RESPONSIBILITIES

You have a RIGHT:

- To ask for help to complete your application or any other DHS form.
- To ask for forms and notices to be translated if you don't read English and to be provided with information in a format you can understand.
- To be treated with courtesy, consideration and respect.
- To be interviewed promptly when you apply and to have your eligibility determined within 30 days.
- To discuss your case with your DHS worker and to review your case when you request to do so.
- To receive Food Stamps within seven (7) days if you are eligible for expedited Food Stamps.
- To have a written notice mailed to you when your application is approved, denied, or when your benefits decrease or stop.
- To have your records kept confidential by DHS, unless otherwise provided for by law and to receive a hard copy of the DHS notice of privacy practices outlining your individual privacy rights and protections.
- To file a complaint or appeal and to ask for a hearing within 90 days for Food Stamps, of any action on your benefits that you think was wrong.
- To be represented at a hearing by yourself or a household member, friend, attorney, or other person of your choice. (You may get free legal help at your local RI Legal Services office – 274-2652.)
- To refuse to provide information on your racial/ethnic heritage.
- To not be discriminated against, according to applicable Federal and State laws, on the basis of race, color, national origin, disability, sex, political beliefs, age, religion or sexual orientation.

You have a RESPONSIBILITY:

- To give the Department accurate information about your household's income, resources and living arrangements. (Making false statements or failing to report all the facts or situations that affect eligibility for benefits may result in stopping your household's benefits, repayment of benefits received incorrectly, and/or criminal or civil action.)
- For Food Stamps: to tell us immediately (within 10 days) of any changes in your household's income, resources, members, employment status, or other information you supplied on your application. This will allow DHS to be sure your household is receiving the correct type and amount of benefits.
- To tell us about and provide proof of shelter, medical and dependent care costs. If you do not report or provide proof of these costs, they will not be used to help figure your benefits.
- To cooperate fully with State and Federal personnel conducting Quality Control reviews. This is a random selection of cases to be reviewed.
- To supply Social Security numbers for all members of your household who are required to have one, or to apply for them as a condition of eligibility. These Social Security numbers will be used in a computer match with other government agencies, and will be verified electronically where possible. Income and eligibility information obtained will be used to make sure your household or the person who has applied for benefits are eligible for and receiving the correct amount of benefits.

I UNDERSTAND that by signing this application:

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- DHS can pursue any payments that may be due from a third party as a result of an accident, injury, or illness, including any claims for Workers' Compensation.
- DHS can obtain from medical providers, information that is pertinent to me or any person included in this application for as long as my case remains open.
- DHS can contact other persons or organizations to get proof of my eligibility and level of benefits.
- DHS has my consent to use or disclose protected health information for the purposes of treatment, payment and health care operations in accordance with DHS notice of privacy practices.
- DHS can use information on this application for the administration of DHS programs as well as the administration of other federally funded assistance programs.
- DHS can release non-identifying information for research purposes. (IMPORTANT: NO NAMES, SOCIAL SECURITY NUMBERS, OR ADDRESSES WILL BE RELEASED)

I understand my rights and responsibilities. I agree to comply with my responsibilities. I also understand that penalties for giving wrong or incomplete facts and failing to report facts or situations which may affect my eligibility or benefit level may result in fines or imprisonment. I certify under penalty of perjury that all of the information contained in this application is true.

SIGN HERE

Signature of Applicant (Adult household member or Authorized Representative)	Date	Signature of Spouse	Date
Signature of Other Parent Living In the home/Guardian	Date	Signature of person who helped fill out application	Date
Signature of Agency Representative	Date	Signature of Interpreter	Date